Supreme Court, U.S.
FILED
SEP 15 1993
OFFICE OF THE CLERK

No. 93-105

In the Supreme Court of the United States

OCTOBER TERM, 1993

BLUE CROSS AND BLUE SHIELD OF MARYLAND, INC.,
PETITIONER

v.

UNITED STATES OF AMERICA

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FOURTH CIRCUIT

BRIEF FOR THE UNITED STATES IN OPPOSITION

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QUESTION PRESENTED

Whether, under its Medicare supplemental health insurance (medigap) policies, petitioner may deny reimbursement to a Veterans Administration hospital for medical services that are provided to Medicare-eligible patients, but for which the Medicare program does not provide reimbursement.

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OPINIONS BELOW

The opinion of the court of appeals (Pet. App. 1a-20a) is reported at 989 F.2d 718. The opinion of the district court (Pet. App. 21a-25a) is reported at 790 F. Supp. 106.

JURISDICTION

The judgment of the court of appeals was entered on March 22, 1993, and a petition for rehearing was denied on April 16, 1993. Pet. App. 26a. The petition for a writ of certiorari was filed on July 15, 1993. The jurisdiction of this Court is invoked under 28 U.S.C. 1254(1).

STATEMENT

1. a. This case arises from petitioner's refusal to honor the request by the Veterans' Administration (VA) (now the Department of Veterans Affairs) for reimbursement for the costs of medical services that the VA rendered free of charge to eleven Medicare-eligible veterans. These veterans were covered by Medicare supplemental (medigap) insurance policies issued by petitioner. Under the Veterans' Benefits Act of 1957, 38 U.S.C. 1701 *et seq.*, a veteran may receive medical care in a VA medical facility for a non-service connected disability if the veteran is unable to defray the cost of such care. 38 U.S.C. 1710(a)(1)(I). In 1981, Congress enacted a provision to permit the VA to recover the reasonable costs of caring for a veteran's non-service-connected disability from third parties that would ordinarily provide compensation for the cost of such care had it not been provided by the VA. Veterans' Health Care, Training, and Small Business Loan Act of 1981, Pub. L. No. 97-72, Tit. I, § 106, 95 Stat. 1050-1051. That provision was specifically amended in 1986 to give the United States authority to pursue recovery from a veteran's medical insurer. See Consolidated Omnibus Budget Reconciliation Act of 1985, Pub. L. No. 99-272, Tit. XIX, § 19013, 100 Stat. 382-385 (codified as amended at 38 U.S.C. 1729).[1] Because 38 U.S.C. 1729 was intended to put the VA on an equal footing with all other providers of medical services—and thus to prohibit insurers from denying reimbursement to the VA when reimbursement would otherwise be paid to private hospitals—it has generally been

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[1] This provision was originally codified at 38 U.S.C. 629, but was amended and renumbered in 1991. See Department of Veterans Affairs Codification Act, Pub. L. No. 102-83, § 5(a), 105 Stat. 406 (1991) (codified as amended at 38 U.S.C. 1729).

referred to as the "nondiscrimination" provision.[2] The statute further provides that no state law and "no provision of any contract or other agreement, shall operate to prevent recovery or collection by the United States under this section." 38 U.S.C. 1729(f).

Section 1729 states that the third parties from which the United States may recover the costs of medical services include States, employers, automobile insurance carriers, and persons "obligated to provide, or to pay the expenses of, health services under a health-plan contract." 38 U.S.C. 1729(i)(3)(D). The term "health-plan contract" is defined as "an insurance policy or contract, medical or hospital service agreement, membership or subscription contract, or similar arrangement, under which health services for individuals are provided or the expenses of such services are paid." 38 U.S.C. 1729(i)(1)(A).

b. Part A of the Medicare program is a medical insurance program providing coverage for hospital care and related hospital services to persons who are over sixty-five years of age and who are eligible for Social Security retirement benefits. 42 U.S.C. 1395c. The Medicare Act and its implementing regulations set forth the conditions and limitations on the coverage of listed services and items and limit the reimbursable reasonable charge

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[2] 38 U.S.C. 1729(a)(1) provides:

> Subject to the provisions of this section, in any case in which a veteran is furnished care or services under this chapter for a non-service-connected disability described in paragraph (2) of this subsection, the United States has the right to recover or collect the reasonable cost of such care or services (as determined by the Secretary) from a third party to the extent that the veteran (or the provider of the care or services) would be eligible to receive payment for such care or services from such third party if the care or services had not been furnished by a department or agency of the United States.

for covered services. See 42 C.F.R. Pts. 409, 410. There are certain circumstances under which Medicare will not pay claims even though a patient qualifies for benefits and the services he receives are covered under the Act and regulations. As relevant to this case, Medicare reimbursement is denied when: (1) the health care provider is a federal department or agency, 42 U.S.C. 1395f(c), 1395n(d); and (2) the patient is not obligated to pay for the services provided, 42 U.S.C. 1395y(a)(3). Congress also specifically excluded Medicare from the definition of "health-plan contract" under 38 U.S.C. 1729(i)(1)(B)(i), thus preventing the VA from billing Medicare for the medical services it provides to Medicare-eligible patients.[3] The effect of these exclusions is to prevent VA hospitals from receiving Medicare reimbursement for medical services provided to veterans for non-service-connected disabilities for which the veterans are unable to pay.

In addition to barring reimbursement for covered services under circumstances such as those just described, Medicare does not reimburse for the full cost of certain health care services and does not cover other services (such as outpatient prescription drugs) at all. Thus, patients remain responsible for paying various charges, deductibles and coinsurance amounts. See 42 U.S.C. 1395e(a)(3). To insure against these costs, Medicare participants often purchase Medicare supplemental or "medigap" policies from private insurers. Congress amended the Medicare Act in 1980 specifically to define medigap policies. See Social Security Disability Amendments of 1980, Pub. L. No. 96-265, § 507, 94 Stat.

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[3] As the court of appeals in this case explained, this exclusion serves "to avoid the unnecessary transfer of federal funds from Medicare to the VA when the money is all coming out of the same coffer." Pet. App. 16a n.5.

476 (the Baucus Amendment) (codified as amended at 42 U.S.C. 1395ss). Section 1395ss defines a medigap policy to include (42 U.S.C. 1395ss(g)(1)):

> a health insurance policy or other health benefit plan offered by a private entity to individuals who are entitled to have payment made under this subchapter, which provides reimbursement for expenses incurred for services and items for which payment may be made under this subchapter but which are not reimbursable by reason of the applicability of deductibles, coinsurance amounts, or other limitations imposed pursuant to this subchapter
> * * *

2. Petitioner Blue Cross and Blue Shield of Maryland (BCBS) is a private health insurance carrier that issues medigap policies in Maryland. The United States submitted claims to petitioner for reimbursement on behalf of eleven veterans who held medigap policies issued by petitioner and who had received medical care at a VA medical facility. Petitioner denied the claims on the ground that its medigap policies covered only those medical expenses incurred in a manner that would also trigger Medicare reimbursement. Because the VA was not entitled to receive Medicare payments for the VA services, see 42 U.S.C. 1395f(c), 1395n(d) and 1395y(a)(3), the insurer denied the government's claims. The United States then instituted this action in federal district court to recover benefits under the veterans' BCBS medigap policies, arguing that the nondiscrimination provision of the Veterans' Benefits Act of 1957, 38 U.S.C. 1729, prohibited petitioner from refusing to pay.

The district court granted summary judgment in favor of the United States. Pet. App. 21a-25a. The court rejected petitioner's defense that because VA hospitals are not entitled to receive Medicare reimbursement, the

government may not receive any payment for the cost of care under private medigap policies. The court observed that the Medicare Act's definition of a medigap policy "as a 'health insurance policy' or 'other health benefit plan'" (*id.* at 23a), see 42 U.S.C. 1395ss, falls plainly within the broad definition of "health-plan contract" contained in Section 1729 of the Veterans' Benefits Act of 1957. Pet. App. 23a. The court therefore concluded that "Congress clearly intended Section 1729 to apply to Medicare Supplemental Contracts." *Ibid.*

3. The court of appeals affirmed. Pet. App. 1a-20a. The court refused to accept petitioner's suggestion "that there is a federal statutory requirement that medigap policies operate necessarily and exclusively in tandem with Medicare payments," explaining that that argument "confuses a person's entitlement to Medicare benefits with her actual ability to collect those benefits." Pet. App. 9a-10a. In the court of appeals' view, the statutory provision barring Medicare payments to VA hospitals is simply "a limitation to Medicare recovery but not to eligibility for the underlying benefits." *Id.* at 10a.

The Fourth Circuit further explained that a veteran who is Medicare-eligible, and therefore would be entitled to receive benefits but for his treatment at a VA hospital, is in a situation "not unlike two other circumstances where a medigap policy *will* pay despite the failure of Medicare to make reimbursement." *Ibid.* The first situation noted by the court arises because Medicare will not pay until other potential payers under a group health plan or workers' compensation program first make payment. See 42 U.S.C. 1395y(b)(2). As the court explained, Pet. App. 11a:

> If a workers' compensation claim covers all expenses possibly recoverable as Medicare benefits but excludes the deductibles and coinsurance amounts excluded by Medicare, then [petitioner] will be faced

> with a claim under its medigap policy for reimbursement for those unrecoverable amounts. BCBS will be asked to reimburse those amounts it would have reimbursed had Medicare acted as the primary payer, not workers' compensation.

In the second instance cited by the appeals court, BCBS medigap policies will pay for hospital services provided outside the United States under circumstances in which the Act provides that no Medicare payment whatsoever shall be made. *Ibid.*; see 42 U.S.C. 1395f(f)(1). In light of these examples, the court concluded that "[c]learly, medigap policies can be 'triggered' without payment of a Medicare benefit." Pet App. 16a.[4]

Finally, the court rejected petitioner's contention that a medigap policy is not a "health-plan contract" within the meaning of that statutory term and thus does not fall within the scope of Section 1729's nondiscrimination provision. Specifically, the court stated that a "health-plan contract need do only one of two things—provide health services or reimburse the expenses of such services." Pet. App. 19a; see 38 U.S.C. 1729(i)(1)(A). Continuing further, the court stated that, "[w]ithout a doubt, medigap policies were designed to do just that by paying 'benefits [which] are for services billed for by the hospital, physician, or provider.'" Pet. App. 19a. The court therefore held that petitioner's medigap policies are health-plan contracts governed by the nondiscrimination and reimbursement provisions of 38 U.S.C. 1729. *Ibid.*

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[4] The court of appeals also concluded that petitioner's "suggested interpretation of the medigap policies operates to discriminate against VA hospitals, and that discrimination is rooted in [petitioner's] contract, not state or federal law." Pet. App. 14a. The court "reject[ed] any interpretation of [petitioner's] contract or federal law suggested by [petitioner] that operates to deny reimbursement to VA hospitals." *Ibid.*

ARGUMENT

The decision of the court of appeals is correct and does not conflict with any decision of this Court or any other court of appeals. Indeed, the other federal courts that have directly addressed the question have likewise held that private insurers may not refuse to reimburse the VA for costs that would otherwise be paid to a private hospital under the terms of so-called "medigap" policies. See *United States* v. *Capital Blue Cross*, 992 F.2d 1270 (3d Cir. 1993); *United States* v. *Blue Cross/Blue Shield of Alabama*, No. 92-6521 (11th Cir. Sept. 8, 1993). Review by this Court is therefore unwarranted.

1. Petitioner's main contention (Pet. 3-5) is that, by construing the term "health-plan contract" in Section 1729(i)(1)(A) to apply to medigap policies—thus holding those policies to the principle of nondiscrimination under 38 U.S.C. 1729—the court of appeals' decision effects a "repeal by implication" of the statutory definition of a medigap policy in the Baucus Amendment to the Medicare Act, 42 U.S.C. 1395ss(g)(1). However, the rule disfavoring implied repeals, on which petitioner relies, is simply not implicated here, because Section 1729 does not repeal any provision of the Baucus Amendment. To the contrary, treating petitioner's medigap policy as a "health-plan contract" under Section 1729 is fully consistent with the definition of a medigap policy in the Baucus Amendment.

The pertinent provision of the Baucus Amendment, 38 U.S.C. 1395ss(g)(1), defines a medigap policy as a private "health insurance policy * * * which provides reimbursement for expenses incurred for services * * * which are not reimbursable by reason of the applicability of deductibles, coinsurance amounts, or *other limitations* imposed pursuant to this subchapter" (emphasis added). Under a straightforward reading of that statutory text, a policy that promises to pay for services that

are "not reimbursable" under Medicare at all because of specific statutory limitations would come within the definition of a "medigap" policy. In this case, the pertinent "limitations" are sections of the Medicare Act that deny Medicare reimbursement for certain services rendered by the VA to Medicare beneficiaries free of charge. Thus, a policy that paid for those services would meet the criteria for a medigap policy in Section 1395ss(g)(1).

Nothing in the Baucus Amendment suggests that the "limitations" to which it refers would not include statutory denials of Medicare reimbursement for particular services, such as medical care provided by the VA. Thus, there is no reason to believe that the Baucus Amendment permits Medicare supplemental policies to pay benefits only when Medicare is the primary payer for a service. As the court of appeals pointed out, that argument does not square with petitioner's practice of providing payment under its medigap policies for services for which Medicare provides no reimbursement whatsoever. See Pet. App. 10a-11a, 16a.

2. Petitioner alternatively argues (Pet. 6) that Congress's use of the word "means" in defining a "health-plan contract" in 38 U.S.C. 1729(i)(1)(A) excludes any particular form of insurance policy that is not expressly mentioned. Since Section 1729(i)(1)(A) "does not specify a medigap policy," petitioner contends, the definition of health-plan contract does not include that type of policy. However, Section 1729(i)(1)(A) broadly defines health-plan contract as "an insurance policy or contract, medical or hospital service agreement, membership or subscription contract, or similar arrangement, under which health services for individuals are provided or the expenses of such services are paid." As the court of appeals held, this definition requires that a health-plan contract do only one of two things: "provide health services or reimburse the expenses of such services." Pet.

App. 19a. A medigap policy plainly qualifies as a policy "under which * * * the expenses of [health] services are paid." 38 U.S.C. 1729(i)(1)(A).[5]

3. Petitioner points (Pet. 10-12) to two instances in which Congress declined to pass legislation amending 38

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[5] Petitioner asserts (Pet. 6) that the legislative history of the 1986 amendments to Section 1729 further supports its contention because that history does not specifically refer to medigap policies. As the court of appeals concluded, however, the legislative history, if anything, undermines petitioner's construction. Citing a report of the Senate Budget Committee, the court pointed out that Congress intended the definition of health-plan contract "to be construed broadly so as to achieve broad coverage under this section with respect to the types of health plans under which recoveries and collections may be sought." Pet. App. 15a-16a (quoting S. Rep. No. 146, 99th Cong., 2d Sess. 633 (1986)). This language does not reveal a congressional intent to define the category of health-plan contracts narrowly so as to exclude medigap policies from the definition. Pet. App. 16a. See also H.R. Rep. No. 300, 99th Cong., 1st Sess. 790 (1985), discussed in *Capital Blue Cross*, 992 F.2d at 1274.

Petitioner also relies on a passage in the legislative history of the 1986 amendments stating that the amendments were designed to add sources of reimbursement from third parties "such as an employee health care insurer" to the categories of payers obligated to provide nondiscriminatory reimbursement to the VA. Petitioner argues that this passage shows that Congress could not have intended to include a medigap policy within the meaning of "health-plan contract," because there is a "fundamental distinction" (Pet. 8) between "employee health care insurers," which customarily provide primary health insurance or "first dollar benefits," and medigap policies, which are designed to supplement other sources of insurance. However, the legislative remarks do not indicate that Congress sought to draw a distinction between those two types of insurance plans. Rather, in mentioning an "employee health care insurer" as only one example of a private third party payer from which the VA is entitled to seek reimbursement, the report implies that other categories of private insurance—not necessarily limited to the type of "primary" health care plan customarily issued by employers—would also be available as sources of payment under the amended statute.

U.S.C. 1729(i)'s definition of a "health-plan contract" to include a specific reference to medigap policies. See S. 1271, 102d Cong, 1st Sess. § 2 (1991); S. 2455, 101st Cong., 2d Sess. § 5 (1990). Those proposals to amend Section 1729 to make the inclusion of medigap policies explicit, however, does not establish that those types of policies are currently excluded from the statutory definition. As an initial matter, "Congress's rejection of a proposed amendment is not a significant aid in interpreting a statute passed years earlier." *Capital Blue Cross*, 992 F.2d at 1277 (citing 2A N. Singer, *Sutherland on Statutes and Statutory Construction* § 48.18 (5th ed. 1992)). Moreover, as the court of appeals concluded, the legislative history suggests that the purpose of the proposed amendment to Section 1729(i) was merely to clarify the original scope of the term "health-plan contract," not to expand it. Pet. App. 18a; accord *Capital Blue Cross*, 992 F.2d at 1277 (It is "at least * * * likely" that the proposed amendments were designed to clarify Congress's initial intent in the face of ensuing "controversy over the scope of the definition" of the term "health plan contract").[6] Therefore, the unenacted bills

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[6] Petitioner also points (Pet. 9-10) to Congress's decision in 1990 to amend 10 U.S.C. 1095 (a statute analogous to 38 U.S.C. 1729, see *Capital Blue Cross*, 992 F.2d at 1276) expressly to include providers of Medicare supplemental insurance within the category of third party payers from which the Department of Defense (DOD) is entitled to collect payment, on a nondiscriminatory basis, for the costs of medical services provided directly to military personnel. That enactment was in response to DOD's interpretation of its nondiscrimination provision—which, like Section 1729, prohibited DOD from collecting payment from Medicare for the services it provides for free—as implying a similar exclusion for medigap policies. See Pet. 10. As the Third Circuit concluded in response to this argument, however, Congress's immediate action in the wake of DOD's interpretation of Section 1095 is most plausibly viewed as "signalling that DOD had adopted an unduly broad read-

do not support petitioner's contention that medigap policies are not subject to Section 1729's principle of nondiscrimination in payment to the VA.

CONCLUSION

The petition for a writ of certiorari should be denied.

Respectfully submitted.

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ing of the Medicare exclusion" that was contrary to Congress's original intent. See *Capital Blue Cross*, 992 F.2d at 1276. Thus, Congress's decision to amend Section 1095 expressly to permit DOD to receive reimbursement under medigap policies was most likely designed to clarify, rather than to expand, the reach of the original version of the statute.